Appendix D: Intensive Community Based Support Youth

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Appendix D: Intensive Community Based Support Youth

Definitions

“Assessment” means the face-to-face interaction in which the provider obtains information from the youth, and parent, guardian, or other family members, as appropriate, about the youth’s behavioral health status and behaviors. It includes documented history of the severity, intensity, and duration of behavioral health problems and behavioral and emotional issues.

“Collateral Contact” means face-to-face or telephonic exchange between the behavioral health provider of an individual and the individual’s authorized representative and others engaged in the individual’s wellness for the purpose of care coordination. The following is a list of typical collateral contacts: family members, teachers, principals, primary care clinicians, guidance counselors, day care provider staff, previous therapists, attorneys or other staff from the courts, state agencies, social service agencies, outreach programs, after-school programs, community centers, and behavioral health providers at another level of care such as inpatient providers.

"Crisis intervention" means behavioral health care, available 24-hours per day, seven days per week, to provide immediate assistance to individuals experiencing acute behavioral health problems that require immediate intervention to stabilize and prevent harm and higher level of acuity.

“FFT Professional” means a mental health professional (must be QMHP-E, QMHP-C, CSAC, CSAC-supervisee, LMHP-R, LMHP-S, LMHP-RP, or LMHP) who is qualified to delivery Functional Family Therapy as part of a licensed FFT Team that has been licensed by FFT, LLC. FFT treatment developers refer to this same role as an “FFT Therapist” but for the purposes of Virginia DMAS definition, “FFT Professional” will be the official term. FFT Professionals operate under oversight of an FFT Supervisor within the collaborative mental health model and may not function outside a licensed FFT team.

"FFT Supervisor" means a mental health professional (must be LMHP-R, LMHP-S, LMHP-RP, or LMHP) who is qualified by FFT, LLC to serve as a subject matter expert ("supervisor") and acts as a lead on a certified FFT team. This role provides guidance and oversight to promote fidelity of the FFT model. This individual may or may not also serve as a Clinical Supervisor of record to sign off on documentation of hours required for supervision per the Department of Health Professions regulations depending on whether the individual meets requirements of such and are supervising an FFT Professional who is pursuing licensure from the same board under which the FFT Supervisor is licensed.

"MST Professional" means a mental health professional (must be QMHP-E, QMHP-C, CSAC, CSAC-supervisee, LMHP-R, LMHP-S, LMHP-RP, or LMHP) who is qualified to deliver Multisystemic Therapy as part of an MST team licensed by MST Services. MST treatment developers refer to this same role as an "MST Therapist" but for the purposes of Virginia DMAS definitions, "MST Professional" will be the official term. MST Professionals operate under oversight of an MST Supervisor within the collaborative mental health model and may not function outside of a certified MST team.

"MST Supervisor" means a mental health professional (must be LMHP-R, LMHP-S, LMHP-RP, or LMHP) who is qualified by MST Services to serve as a subject matter expert ("supervisor") and acts as a lead on a licensed MST team. This role provides guidance, training and oversight to promote fidelity of the MST model, as defined within the MST Supervision model. This individual may or may not also serve as a Clinical Supervisor of record to sign off on documentation of hours required for supervision per the Department of Health Professions regulations depending on whether they meet requirements of such and are supervising an MST Professional who is pursuing licensure from the same board under which the MST Supervisor is licensed.

"Therapeutic Interventions" means evidence based, individualized or family focused interventions designed to decrease symptoms of the mental health diagnosis, reduce maladaptive behaviors and increase pro-social behaviors at home and across the multiple interconnected systems (includes family, extended family, peers, neighbors, and other community members relative to the youth). All family interventions are for the direct benefit of the individual, in accordance with the individual's needs and treatment goals identified in the ISP. Therapeutic Interventions are also referred to as "contacts" by MST Services, Inc.

The following definitions found in Chapter II of this manual, apply to this Appendix:

- Certified substance abuse counselor (CSAC)
- CSAC-supervisee
- Licensed assistant behavior analyst (LABA)
- Licensed behavior analyst (LBA)

- Licensed mental health professional (LMHP)
- LMHP-resident (LMHP-R)
- LMHP-resident in psychology (LMHP-RP)
- LMHP-supervisee in social work (LMHP-S)
- QMHP-child (QMHP-C)
- QMHP-eligible (QMHP-E)

The following definitions found in Chapter IV of this manual, apply to this Appendix:

- At Risk of Out of Home Placement
- Care Coordination
- Comprehensive Needs Assessment
- Counseling
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT)
- Individual Service Plan (ISP)
- Treatment Planning
- Youth

Multisystemic Therapy (MST) (effective 12/1/2021)

MST Level of Care Guidelines	
Service Definition	Multisystemic Therapy (MST) is an intensive family and community-based treatment which addresses the externalizing behaviors of youth with significant clinical impairment in disruptive behavior, mood, and/or substance use. MST is provided using a home-based model of service delivery for youth and families, targeting youth between the ages of 11 - 18 who are at high risk of out- of-home placement, or may be returning home from a higher level of care. MST services are delivered in the natural environment (e.g., home, school, community) with the treatment plan being designed in collaboration with the youth, family, and all relevant child serving systems (e.g. DJJ, DSS, Mental Health, PCP, Education, Faith-based organizations, etc.) Multi-systemic therapy (MST) is an intensive, evidence-based treatment program provided in home and community settings for youth who have received referral for the treatment of behavioral or emotional problems by the juvenile justice, behavioral health, school, or child welfare systems. MST is targeted towards youth between the ages of 11 - 18, however, the service is available to any youth under the age of 21 who meets medical necessity criteria. MST is appropriate for youth with significant clinical impairment in disruptive behavior, mood, and/or substance use. MST includes an engagement with the youth's family, caregivers and natural supports and professionals delivering interventions in the recovery environment. MST is a short-term and rehabilitative service that may serve as a step-down or diversion from higher levels of care and seeks to understand and intervene with youth within their network of systems including family, peers, school, and neighborhood/community.

Critical Features & Service Components	Critical Features of MST include the following: • Integration of evidence-based therapeutic interventions to address a comprehensive range of risk factors across family, peer, school, and community contexts; • Promotion of behavior change in the youth's natural environment, with the overriding goal of empowering caregivers; • Rigorous quality assurance mechanisms that focus on achieving outcomes through maintaining treatment fidelity and developing strategies to overcome barriers to behavior change; and • MST professionals on call 24/7 to provide safety planning and crisis intervention. MST is based on the philosophy that the most effective and ethical way to help children and youth is by helping their families. MST views caregivers as valuable resources, even when many of them have serious and multiple needs of their own. One primary goal of MST is to empower caregivers to effectively parent their children. MST treatment reaches across all of the youth's life domains and is highly individualized around each case. MST Professionals may provide the therapeutic interventions involved in MST in a range of community settings such as the youth's home, school, homeless shelters, libraries, etc. MST includes therapeutic intervention and care coordination to assist the youth in meeting their specific goals. MST Professionals deliver this service primarily face-to-face with the youth and their natural supports in locations outside of the provider's facility. MST therapeutic intervention sessions are tailored by a MST Treatment Plan. Service intensity varies with the needs of the youth and family/caregiving system. Early in treatment, the MST Professional may meet with the family several times a week, but as treatment progresses, the intensity tapers. The frequency of therapeutic interventions is flexible based on clinical need, allowing the service to be responsive to periods of crisis or high risk and to decrease the intensity for families with lower levels of need. The MST model expects the MST Professional to take the lead on coordinating care while youth are participating in MST services. Therapeutic interventions and collateral contacts may range from brief check-ins to more intensive sessions lasting up to two-hours or more. The required supervision, consultation and monitoring provided through the evidence-based MST model work to uphold treatment fidelity expectations around service delivery intensity/frequency. The frequency, intensive and duration of MST services is dependent on the needs of the youth as described in the ISP. If not in conflict with the ISP for a particular youth, the MST model expects an average of 10-20 therapeutic interventions occur within the first month but should ultimately be tailored to the needs of the youth. These initial therapeutic interventions typically occur multiple times per week in frequency. For the second and third months of MST, an average of six therapeutic interventions typically occur per month, though vary based on the needs of the youth. The MST model expects that service frequency will be tapered over the duration of the treatment period based on the youth's needs. Close to treatment termination, the MST professional contacts the family as needed to assure that treatment gains have been maintained by the family. Documentation should be made of each therapeutic intervention or collateral contact and include the reason, outcome and next steps; these details should all relate to the goals of the ISP. Service components of MST include: • Assessment • Therapeutic interventions • Crisis intervention and • Care coordination

Required Activities	In addition to the required activities for all mental health services providers located in Chapter IV, the following required activities apply to MST: • At the start of services, a LMHP, LMHP-R, LMHP-RP, LMHP-S, shall conduct an initial assessment consistent with the components required in the Comprehensive Needs Assessment (see Chapter IV for requirements), documenting the youth's diagnosis/es and describing how service needs match the level of care criteria. • ISPs shall be required during the entire duration of services and must be current. (see Chapter IV for requirements) The MST Weekly Case Summary form may be used as the ISP if it meets the requirements of an ISP. The treatment planning process should be collaborative but must be directed and authorized by a LMHP, LMHP-R, LMHP-RP, or LMHP-S. In cases where the MST Professional is a QMHP-E, QMHP-C, CSAC or CSAC-supervisee, the MST Supervisor directs and authorizes the treatment planning process as part of the MST model. • ISPs must be reviewed as necessary at a minimum of every 30-calendar days or more frequently depending on the youth's needs. Refer to Chapter IV for additional guidance and documentation requirements for the 30-calendar day review as well as additional quarterly review requirements. These 30 day reviews are consistent and comply with the routine activities required for fidelity in the MST model and include treatment team meetings, consultations with MST supervisors and consultants, meetings with youth and natural supports and administration of fidelity measures. • Crisis intervention must be available on a 24 hours a day, seven days a week, 365 days a year basis. • Providers must follow all requirements for care coordination (See Care Coordination Requirements of Mental Health Providers section of Chapter IV).

Service Limitations	In addition to the "Non-Reimbursable Activities for all Mental Health Services" section in Chapter IV, the following service limitations apply: • The provision of MST is limited to youth under the age of 21. • Youth can participate in MST services with only one MST team at a time. • MST may not be authorized concurrently for the youth* with - Group or Family Therapy, - ARTS Levels 2.1, 2.5, 3.1 and 3.3-4.0, - Community Stabilization, - Functional Family Therapy, - Mental Health Skill Building, - Intensive In-Home Services, - Mental Health Partial Hospitalization Program, - Mental Health Intensive Outpatient, or - Assertive Community Treatment **other family members may be receiving one of the above services and still participate in MST as appropriate for the benefit of the youth receiving MST services* • If the youth continues to meet with an existing outpatient therapy provider, the MST provider must coordinate the treatment plan with the provider. • Other Mental Health and ARTS services, Inpatient Services, and Residential Treatment Services may be authorized and billed concurrently for no more than 14 consecutive calendar days, as the youth are being admitted or discharged from MST to other behavioral health services. • Office based opioid treatment services (OBOT) and Office Based Addiction Treatment (OBAT) services are allowed simultaneously with MST, as are E/M outpatient services for the purposes of psychiatric medication evaluation and management. Activities not authorized or reimbursed within MST: • - Inactive time or time spent waiting to respond to a behavioral situation; - Therapeutic interventions that are not medically necessary; - Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide, or an academic tutor; - Child Care services or services provided as a substitute for the parent or other youth responsible for providing care and supervision; - Respite care; - Transportation for the youth or family. Additional medical transportation for service needs which are not considered part of MST program services may be covered by the transportation service through the FFS Non-Emergency Medical Transportation Broker or MCO. Medical transportation to Medicaid providers may be billed to the transportation broker. - Services not in compliance with the MST manuals and not in compliance with model fidelity standards. - Any art, movement, dance, or drama therapies outside the scope of the MST model fidelity. Recreational activities, such as trips to the library, restaurants, museums, health clubs and shopping centers, which are not part of the ISP. - Services not identified on the youth's authorized ISP. - Anything not included in the approved MST service description. - Any intervention or contact not documented or consistent with the approved treatment/recovery plan goals, objectives, and approved services.
MST Provider Participation Requirements	

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<tr>
<td>Provider Qualifications</td>
<td>MST service providers shall be licensed by DBHDS as a provider of Intensive In-Home Services, be certified and maintain an active program certification with MST Services, Inc., and be credentialed with the youth’s Medicaid MCO for youth enrolled in Medicaid managed care or the Fee for Service (FFS) contractor for youth in FFS. MST providers must follow all general Medicaid provider requirements specified in Chapter II of this manual. MST providers must have the ability to deliver services in the youth’s natural environment and community. Organizations that provide MST must provide crisis intervention on a 24 hours a day, seven days a week, 365 days a year basis, to youth who are receiving this service.
New MST Teams: Any team that is new to enrolling as a Medicaid provider with the Medicaid MCO or FFS contractor. Teams are considered new from the effective date they are credentialed/contracted through an 18-month period.
Established MST Teams: Any team that has been enrolled with a Medicaid MCO or FFS contractor past an 18-month period.
<table>
<tr><td>Bachelor's Established Team</td><td>One MST Professional is Bachelor's Level QMHP-E/QMHP-C/CSAC/CSAC-supervisee
All other team members must be LMHP, LMHP-R, LMHP-S or LMHP-RP</td></tr>
<tr><td>Master's/Licensed Established Team</td><td>One MST Professional is Master's Level QMHP-E/QMHP-C/CSAC/CSAC-supervisee
All other team members must be LMHP, LMHP-R, LMHP-S or LMHP-RP
or the entire team is a LMHP, LMHP-R, LMHP-S, or LMHP-RP.</td></tr>
<tr><td>Bachelor's New Team</td><td>One MST Professional is Bachelor's Level QMHP-E/QMHP-C/CSAC/CSAC-supervisee
All other team members must be LMHP, LMHP-R, LMHP-S or LMHP-RP</td></tr>
<tr><td>Master's/Licensed New Team</td><td>One MST Professional is Master's Level QMHP-E/QMHP-C/CSAC/CSAC-supervisee
All other team members must be LMHP, LMHP-R, LMHP-S or LMHP-RP
or the entire team is a LMHP, LMHP-R, LMHP-S, or LMHP-RP</td></tr>
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Staff Requirements	The MST team composition includes a full-time LMHP, LMHP-R, LMHP-RP, or LMHP-S who acts as the MST Supervisor, and a minimum of two to a maximum of four MST Professionals or at a minimum of one MST Professional and one MST Supervisor if approved by MST Services, Inc. who provide available 24-hour coverage, 7 days a week. MST Professionals include LMHPs, LMHP-Rs, LMHP-RPs, LMHP-Ss, QMHP-Es, QMHP-Cs, CSACs and CSAC-supervisees who meet the requirements of this section. QMHP-E, QMHP-C, CSAC and CSAC-supervisee staff that meet these requirements must be limited to only one MST Professional per MST team and cannot operate as MST Professionals outside of their identified team. CSACs and CSAC-supervisees may only provide services related to substance use disorder treatment per § 54.1-3507.1 and § 54.1-3507.2 MST supervisors are, at minimum, LMHPs, LMHP-Rs, LMHP-RPs, LMHP-Ss with training in behavioral and cognitive behavioral therapies and pragmatic family therapies (e.g., Structural Family Therapy and Strategic Family Therapy). All teams must follow Department of Health Professions (DHP) regulations for clinical supervision requirements of QMHP-Es, QMHP-Cs, CSACs and CSAC-supervisees and LMHP-Rs, LMHP-RPs or LMHP-Ss. • A full-time MST supervisor may supervise: - A single MST Team; or - Two MST teams in the same geographical area; or - One MST team and provide MST services to one or two youth. A MST Professional, on average, may provide service to four to six youth at one time. MST Professionals provide direct intervention and also arrange, coordinate, and monitor services on behalf of the youth. All MST team members are required to participate in MST introductory training and quarterly training on topics directly related to the needs of youth receiving MST and their family on an ongoing basis. The MST model requires that all staff on the MST team shall participate in weekly MST-specific group supervision facilitated by the MST supervisor per MST model standards. All staff on the MST team shall also participate in weekly MST-specific telephone consultation provided by MST Services, Inc. or a licensed MST Network Partner training organization, with no more than 6 weeks a year without consultation due to the occurrence of quarterly trainings and holidays. Assessments must be provided by a LMHP, LMHP-R, LMHP-RP or LMHP-S who meets the qualifications of this section. Therapeutic interventions, crisis intervention and care coordination must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-E, QMHP-C, CSAC or CSAC-supervisee who meets the qualifications of this section.
MST Medical Necessity Criteria	

Admission Criteria Diagnosis, Symptoms, and Functional Impairment	Youth must meet **all** of the following criteria for admission to MST: 1. The youth must be under the age of 21. 2. The initial assessment completed by a LMHP, LMHP-R, LMHP-RP, LMHP-S provides evidence of symptoms and functional impairment that the youth has met criteria for a primary diagnosis consistent with the most recent version of Diagnostic and Statistical Manual that falls within the categories of disruptive behavior, mood, substance use or trauma and stressor-related disorders. There may be additional primary behavioral health diagnoses that may benefit from the interventions of MST that may be considered on a case-by-case basis under EPSDT. 3. Within the past 30 calendar days, the youth has demonstrated at least **one** of the following that puts the youth at risk of out of home placement: 1. Persistent and deliberate attempts to intentionally inflict serious injury on another person; 2. Ongoing dangerous or destructive behavior that is evidenced by repeated occurrences of behaviors that are endangering to self or others are difficult to control, cause distress, or negatively affect the youth's health; 3. Increasing and persistent symptoms associated with depression (e.g. chronic irritability, anhedonia, significant changes in sleep/eating, disrupted emotion regulation, …) or anxiety (e.g. rumination, panic attacks, hypervigilance, dissociation, …), in combination with externalizing problems (e.g. physical and verbal aggression, truancy, stealing, property destruction, lying, etc.) that have contributed to decreased functioning in the community; 4. Ongoing substance use or dependency that interfere with the youth's interpersonal relationships and functioning in the community. 5. The youth is returning home from out-of-home placement and MST is needed as step down service from an out-of-home placement. 4. The youth's successful reintegration or maintenance in the community is dependent upon an integrated and coordinated treatment approach that involves intensive family/caregiver partnership through the MST model. ; Participation in an alternative community-based service would not provide the same opportunities for effective intervention for the youth's problem behaviors. 5. There is a family member or other committed caregiver available to participate in this intensive service. 6. Arrangements for supervision at home/community are adequate to ensure a reasonable degree of safety and a safety plan has been established or will be quickly established by the MST program as clinically indicated.
Exclusion Criteria	Youth who meet any **one** of the criteria below are not eligible to receive MST: • The youth is currently experiencing active suicidal, homicidal or psychotic behavior that requires continuous supervision that is NOT available through the provision of MST. • The youth is living independently, or the provider cannot identify a primary caregiver for participation despite extensive efforts to locate all extended family, adult friends and other potential surrogate caregivers. • The youth's presenting problem is limited to sexually harmful or dangerous behavior in the absence of other externalizing behaviors. • The youth's functional impairment is solely a result of Developmental Disability, as defined in the Code of Virginia § 37.2-100.

Continued Stay Criteria - Diagnosis, Symptoms, and Functional Impairment	Within the past thirty (30) calendar days, MST continues to be the appropriate level of care for the youth as evidenced by at least one of the following: • The youth's symptoms/behaviors and functional impairment persist at a level of severity adequate to meet admission criteria; • The youth has manifested new symptoms that meet admission criteria and those have been documented in the ISP; • Progress toward identified ISP goal(s) is evident and has been documented based upon the objectives defined for each goal, but not all of the treatment goal(s) have been achieved. To consider approval for continued stay requests, documentation will be reviewed and should demonstrate active treatment and care coordination through all of the following: • An ISP with evaluation and treatment objectives appropriate for this level of care and type of intervention. The treatment must support community integrative objectives including the development of the youth's network of personal, family, and community support. Treatment objectives are related to readiness for discharge and MST specific expected outcomes; • Progress toward objectives is being monitored within fidelity to the model as evidenced in the 30 calendar day ISP review documentation; • The youth and family/caregiver are actively involved in treatment, or the provider has documented active, persistent efforts that are appropriate to improve engagement; • The type, frequency and intensity of interventions are consistent with the ISP and fidelity to the model; • The provider is making vigorous efforts to affect a timely transition to an appropriate lower level of care. These efforts require documentation of discharge planning beginning at the time of admission to include communication with service practitioners, community partners, and natural supports that will meet the needs of the client; • The provider has developed an individualized discharge plan that includes specific plans for appropriate follow-up care. If youth does not meet criteria for continued treatment, MST may still be authorized for up to an additional 10 calendar days under any of the following circumstances: • - ▪ • There is no less intensive level of care in which the objectives can be safely accomplished; or • The youth can achieve certain treatment objectives in the current level of care and achievement of those objectives will enable the youth to be discharged directly to a less intensive community service rather than to a more restrictive setting; or • The youth is scheduled for discharge, but the youth requires services at discharge which are still being coordinated and are not currently available. -

Discharge Criteria	The youth meets discharge criteria if any of the following are met: • - ■ The youth's documented ISP goals have been met and the discharge plan has been successfully implemented; ■ The youth and family are not engaged in treatment despite documented efforts to engage and there is no reasonable expectation of progress at this level of care; ■ The youth is placed in an out of home placement, including, but not limited to a hospital, skilled nursing facility, psychiatric residential treatment facility, or therapeutic group home and is not ready for discharge within 31 consecutive calendar days to a family home environment or a community setting with community-based support; ■ Required consent for treatment is withdrawn; or ■ There is a lapse in service greater than 31 consecutive calendar days.
MST Service Authorization and Utilization Review	
Service Authorization	This service requires prior authorization and can only be provided by a treatment provider who is licensed by MST Services, and licensed by the Department of Behavioral Health and Developmental Services for Intensive In-home Services. Providers shall submit service authorization requests within one business day of admission for initial service authorization requests and by the requested start date for continued stay requests. If submitted after the required time-frame, the begin date of authorization will be based on the date of receipt. • Service units are authorized based on medical necessity with a unit equaling fifteen minutes • The following should be included with Continued Stay requests: - The continued stay service authorization form - Updated ISP that reflects the current goals and interventions - Original Comprehensive Needs Assessment and an addendum to this assessment (can be in a progress note) that briefly describes any new information impacting care, progress and interventions to date, and a description of the rationale for continued service delivery. The information provided for service authorization must be corroborated and in the provider's clinical record. An approved Service Authorization is required for any units of MST to be reimbursed. Additional information on service authorization is located in Appendix C of the manual. Service authorization forms and information on Medicaid MCOs processes are located at www.dmas.virginia.gov/for-providers/behavioral-health/training-and-resources/.
Documentation and Utilization Review	Refer to Chapter VI of this manual for documentation and utilization review requirements.

MST Billing Guidance

One unit of service equals fifteen minutes. To bill a service unit, a qualified MST team member must provide a covered service for a minimum of 15 minutes.

Crisis Intervention activities provided by the MST team shall be reimbursed using the Multisystemic Therapy procedure code as a covered service component.

The MST team should be utilized whenever possible as the crisis responder, however, Mobile Crisis Response (H2011) may be dispatched and provide crisis intervention in an emergency.

Providers must bill with the appropriate team modifiers:

Modifier	**Modifier Meaning**
HN	Established Team with one (QMHP-C/E or CSAC/S)-Bachelor's Level Degree
HO	Established Team with one (QMHP-C/E or CSAC/S)-Masters' Level Degree **or** All LMHP types
HK, HN	New Team with one (QMHP-C/E or CSAC/S) Bachelor's Level Degree
HH, HO	New Team with one (QMHP-C/E or CSAC/S)-Masters' Level Degree **or** All LMHP types

Coverage of services delivered by telehealth are described in the "Telehealth Services Supplement". MCO contracted providers should consult with the contracted MCOs for their specific policies and requirements for telehealth.

Billing Code	Unit	Description	Notes	Provider Qualifications
H2033 and modifiers as appropriate	Per 15 minutes	Multisystemic Therapy		LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-C, QMHP-E, CSAC, CSAC-supervisee

H2033 and modifiers as appropriate	Per 15 minutes	Comprehensive Needs Assessment		LMHP, LMHP-R, LMHP-RP, LMHP-S
90791	n/a	Psychiatric Diagnostic Evaluation	This code should be used when a LMHP, LMHP-R, LMHP-RP or LMHP S conducts the comprehensive needs assessment, determines that the youth does not meet MNC and will not enter the service.	LMHP, LMHP-R, LMHP-RP, LMHP-S

Functional Family Therapy (FFT) (effective 12/1/2021)

FFT Level of Care Guidelines	
Service Definition	Functional Family Therapy (FFT) is a short-term, evidence-based treatment program for youth who have received referral for the treatment of behavioral or emotional problems including co-occurring substance use disorders by the juvenile justice, behavioral health, school, or child welfare systems. FFT addresses both symptoms of serious emotional disturbance in the identified youth as well as parenting/caregiving practices and/or caregiver challenges that affect the youth and caregiver's ability to function as a family. The FFT model serves as a step-down or diversion from higher levels of care and seeks to understand and intervene with the youth within their network of systems including, family, peers, school and neighborhood/community. FFT is targeted towards youth between the ages of 11 - 18, however, the service is available to any youth under the age of 21 who meets medical necessity criteria.
Critical Features & Service Components	FFT is a phase-based service that addresses youth behavior problems by systematically targeting risk and protective factors at multiple levels in the youth's environment. In order to accomplish these changes in the most effective manner, FFT includes five major phases that build upon each other through treatment. These phases include engagement, motivation, relational assessment, behavior change and generalization. Specific fidelity standards guide the delivery of FFT services and providers are required to follow these standards. The critical features of the FFT model include: • A philosophy about people that includes an attitude of respectfulness, of individual difference, culture, ethnicity, and family composition. • A focus on family that involves alliance building and involvement with all family members with FFT professionals who do not "take sides" and who avoid being judgmental. • A change model of care focused on risk and protective factors. • An inclusive list of interventions that are specific and individualized for the unique challenges, diverse qualities, and strengths of all families and family members. • An inter-relational focus versus individual problem focus. FFT is primarily a home-based service, but providers may conduct the service in clinic settings, as well as in schools, child welfare facilities, probation and parole offices/aftercare systems and mental health and Substance Use Disorder treatment facilities. The FFT professional meets with the whole family and does not organize service delivery around an individual participant. FFT delivery includes both the clinical interventions as well as the care coordination activities that are necessary for the participants in the service. FFT professionals work with families to assess family behaviors that maintain problem behaviors, modify dysfunctional family communication, train family members to negotiate effectively, set clear rules about privileges and responsibilities, and generalize changes to community contexts and relationships. Each of the FFT phases has its own goals, focus and intervention strategies/techniques, and these are summarized below: **Engagement** • Goals: Enhancing the youth's perceptions of FFT professional responsiveness and credibility; • FFT Professional's Focus: Immediate responsiveness to family needs and maintaining a strength-based relational perspective; and • Activities: High availability, therapeutic interventions with as many family members as possible. **Motivation** • Goals: Creating a positive motivational context by decreasing family hostility, conflict and blame, increasing hope and building balanced alliances with family members; • FFT Professional's Focus: Changing the meaning of family relationships by emphasizing possible hopeful alternatives, maintaining a non-judgmental approach and conveying acceptance and sensitivity to diversity; and • Activities: Interruption of negative interaction patterns, sequencing and reframing of themes presented by family interactions, changing meaning through a strength-based relational focus. **Relational assessment** • Goals: Identifying patterns of interaction within the family to understand the positive interpersonal benefits for individual family members' behaviors; • FFT Professional's Focus: Gathering and analyzing information pertaining to relational processes, and assess each dyad in the family using perception and understanding of relational processes; and • Activities: Observations, questionings, inferences regarding the functions of negative behaviors, and switching from an individual problem focus to a relational perspective. **Behavior Change** • Goals: Reducing or eliminating referral problem(s) by improving family functioning and individual skill development; • FFT Professional's Focus: Focused on improving family communication and teaching new skills to achieve more positive interaction through domain-specific interventions (e.g., problem-solving, anger management, depression, anxiety, substance use, etc.) that are tied to the relational assessment; and, • Activities: Introduction of tasks or skills to the family by providing the rationale for the exercise; coaching, modeling, and rehearsing techniques; and giving feedback along with homework for the family to practice outside of the session. **Generalization** • Goals: Extending the improvements made during the Behavior Change phase into new situations or systems, relapse planning, and incorporating community systems into the treatment process; • FFT professional's focus: Maximizing a multisystemic/systems understanding and ability to establish links, maintain energy, and provider outreach into community systems; and • Activities: Accessing and maintaining connection to community supports, initiating clinical linkages, creating relapse planning, and helping the family to develop independence. It is not a requirement of the FFT model to offer 24/7 access to the FFT professional. Based on referral information and assessment of family risk and protective factors, the FFT provider may increase the frequency and length of sessions. If there is a crisis, the FFT provider may adjust the frequency and length to address the need. The FFT program intentionally includes development skills and interventions to reduce negativity and blame, factors that underlie crisis behavior. Booster sessions are a short term resumption of services initiated by the youth and/or family after successful discharge. Booster sessions may also be planned in advance as part of the discharge planning when the FFT professional is aware of transitional events. Covered services include: • Assessment, • Therapeutic interventions, • Crisis intervention, and • Care Coordination

Required Activities	In addition to the required activities for all mental health services providers located in Chapter IV, the following required activities apply to FFT: • At the start of services, a LMHP, LMHP-R, LMHP-RP, LMHP-S, shall conduct an initial assessment consistent with the components required in the Comprehensive Needs Assessment (see Chapter IV for requirements), documenting the youth's diagnosis/es and describing how service needs match the level of care criteria. • ISPs shall be required during the entire duration of services and must be current (see Chapter IV for requirements). The FFT Behavior Change Session Plan (as defined by FFT, LLC.) can be used as the ISP as long as it includes all of the requirements of an ISP. The treatment planning process should be collaborative but must be directed and authorized by a LMHP, LMHP-R, LMHP-RP, or LMHP-S. In cases where the FFT Professional is a QMHP-E, QMHP-C, CSAC or CSAC-supervisee, the FFT Supervisor directs and authorizes the treatment planning process as part of the FFT model. • The ISP must be reviewed and updated as necessary at a minimum of every 30-calendar days or more frequently depending on the youth's needs. Refer to Chapter IV for additional guidance and documentation requirements for the 30-calendar day review as well as additional quarterly review requirements. These 30 day reviews are consistent and comply with the routine activities required for fidelity in the FFT model and include treatment team meetings, consultations with FFT supervisors and consultants, meetings with youth and natural supports and administration of fidelity measures. • Providers must follow all requirements for care coordination (See Care Coordination Requirements of Mental Health Providers section of Chapter IV).
Service Limitations	In addition to the "Prohibited Activities for all Mental Health Services" section in Chapter IV, the following service limitations apply: • - The provision of FFT is limited to youth under the age of 21. - Youth can participate in FFT services with only one FFT team at a time. - FFT may not be authorized concurrently for a youth* with one or more of the following: ■ Group or Family Therapy, ■ ARTS ASAM Levels 2.1, 2.5, 3.1, 3.3, 3.5, 3.7 and 4.0, ■ Community Stabilization, ■ Multisystemic Therapy, ■ Mental Health Partial Hospitalization Program, ■ Mental Health Intensive Outpatient, ■ Assertive Community Treatment, ■ Mental Health Skill Building, ■ Intensive In-Home Services **other family members may be receiving one of the above services and still participate in FFT as appropriate for the benefit of the youth receiving FFT services* • Other Mental Health and ARTS services, Inpatient Services, and Residential Treatment Services may be authorized and billed concurrently for no more than 14 consecutive calendar days, as the youth are being admitted or discharged from FFT to other behavioral health services. • If the youth continues to meet with an existing outpatient therapy provider, the FFT provider must coordinate the treatment plan with the provider. • Office based opioid treatment services (OBOT) and Office Based Addiction Treatment (OBAT) services are allowed simultaneously with FFT, as are E/M outpatient services for the purposes of psychiatric medication evaluation and management. The following activities are not covered under FFT: • - ■ Inactive time or time spent waiting to respond to a behavioral situation; ■ Supervision hours of the staff; ■ Therapeutic interventions or collateral contacts that are not medically necessary. ■ Time spent doing, attending, or participating in recreational activities. ■ Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide, or an academic tutor. ■ Childcare services or services provided as a substitute for the parent or others responsible for providing care and supervision. ■ Respite care. ■ Transportation for the youth or family. Additional medical transportation for service needs which are not considered part of FFT program services may be covered by the transportation service through the FFS Non-Emergency Medical Transportation Broker or MCO. Medical transportation to Medicaid providers may be billed to the transportation broker. ■ Services not in compliance with the FFT service manual and not in compliance with fidelity standards. ■ Any art, movement, dance, or drama therapies outside the scope of the FFT model fidelity. Recreational activities, such as trips to the library, restaurants, museums, health clubs and shopping centers, which are not part of the ISP. ■ Anything not included in the approved FFT service description. ■ Changes made to FFT that do not follow the requirements outlined in the provider contract, this appendix, or FFT fidelity standards. ■ Any intervention or contact not documented or consistent with the approved treatment/recovery plan goals, objectives, and approved services.
FFT Provider Participation Requirements	
Provider Qualifications	FFT service providers shall be licensed by DBHDS as a provider of Mental Health Outpatient Services, be certified and maintain an active program certification with FFT, LLC., and be credentialed with the youth's Medicaid MCO for youth enrolled in Medicaid managed care or the Fee for Service (FFS) contractor for youth in FFS. FFT providers must follow all general Medicaid provider requirements specified in Chapter II of this manual. FFT providers must follow all general Medicaid provider requirements specified in Chapter II of this manual. New FFT Teams: Any team that is new to enrolling as a Medicaid provider with the Medicaid MCO or FFS contractor. Teams are considered new from the effective date they are credentialed/contracted through an 18-month period. Established FFT Teams: Any team that has been enrolled with a Medicaid MCO or FFS contractor past an 18-month period.
Staff Requirements	FFT utilizes a mandatory group and individual consultation approach, meeting with a national consultant as required by FFT, LLC. . The FFT team is required to complete ongoing trainings to maintain their certification. In accordance with FFT fidelity, one FFT site supervisor may support a team of up to seven trained FFT Professionals. The site supervisor , carries a caseload while also attending FFT supervisor trainings, assuming supervision of the team, attending consultation with a FFT national consultant, completing FFT supervision paperwork and providing ongoing review of the client service system. FFT supervisors and professionals maintain a caseload consistent with the FFT model and monitored by FFT, LLC. FFT Professionals on a team may include LMHPs, LMHP-Rs, LMHP-RPs, LMHP-Ss, QMHP-Es, QMHP-Cs, CSACs and CSAC-supervisees. FFT, LLC certifies by team, not by individual and thus individuals cannot deliver nor bill for FFT if they are operating outside of the team structure. If a certified team includes QMHP-Es, QMHP-Cs, CSACs and CSAC-supervisees, they are limited to 33% of the team being a QMHP-E, QMHP-C, CSAC or CSAC-supervisee. CSACs and CSAC-supervisees may only provide services related to substance use disorder treatment per § 54.1-3507.1 and § 54.1-3507.2 FFTs Supervisors must be a licensed mental health professional (LMHP), LMHP-Resident in Counseling (LMHP-R), LMHP-Resident in Psychology (LMHP-RP) or LMHP-Supervisee in Social Work (LMHP-S). All teams must follow Department of Health Professions (DHP) regulations for clinical supervision requirements of QMHP-Cs, QMHP-Es, CSACs and CSAC-supervisees and LMHP-Rs, LMHP-RPs or LMHP-Ss. Assessments must be provided by a LMHP, LMHP-R, LMHP-RP or LMHP-S. Therapeutic interventions, crisis intervention and care coordination for FFT must be provided by a LMHP, LMHP-R, LMHP-RP, LMHP-S, QMHP-E, QMHP-C, CSAC or CSAC-supervisee who meets the qualifications of this section.
FFT Medical Necessity Criteria	

Bachelor's Established Team	33% of team is Bachelor's Level QMHP-E/QMHP-C/CSAC/CSAC-supervisee All other team members must be LMHP, LMHP-R, LMHP-S or LMHP-RP	33% of team is Bachelor's Level QMHP/CSAC/CSAC-supervisee Rest of team must be LMHP, LMHP-R, LMHP-S, LMHP-RP
Master's/Licensed Established Team	33% of team is Master's Level QMHP-E/QMHP-C/CSAC/CSAC-supervisee All other team members must be LMHP, LMHP-R, LMHP-S or LMHP-RP or the entire team is a LMHP, LMHP-R, LMHP-S or LMHP-RP	33% of team is Master's Level QMHP/CSAC/ CSAC-supervisee Rest of team must be LMHP, LMHP-R, LMHP-S, LMHP-RP
Bachelor's New Team	33% of team is Bachelor's Level QMHP-E/QMHP-C/CSAC/CSAC-supervisee All other team members must be LMHP, LMHP-R, LMHP-S or LMHP-RP	33% of team is Bachelor's Level QMHP/CSAC/ CSAC-supervisee Rest of team must be LMHP, LMHP-R, LMHP-S, LMHP-RP
Master's/Licensed New Team	33% of team is Master's Level QMHP-E/QMHP-C/CSAC/CSAC-supervisee All other team members must be LMHP, LMHP-R, LMHP-S or LMHP-RP or the entire team is a LMHP, LMHP-R, LMHP-S or LMHP-RP	33% of team is Master's Level QMHP/CSAC/ CSAC-supervisee Rest of team must be LMHP, LMHP-R, LMHP-S, LMHP-RP

Admission Criteria Diagnosis, Symptoms, and Functional Impairment	Youth must meet all of the following criteria for admission to FFT: 1. The youth must be under the age of 21. 2. The initial assessment completed by a LMHP, LMHP-R, LMHP-RP, LMHP-S provides evidence of symptoms and functional impairment that the youth has met criteria for a primary diagnosis consistent with the most recent version of Diagnostic and Statistical Manual that falls within the categories of disruptive behavior, mood, substance use or trauma and stressor-related disorders. There may be additional primary behavioral health diagnoses that may benefit from the interventions of FFT that may be considered on a case-by-case basis under EPSDT. 3. Within the past 30 calendar days, the youth has demonstrated at least **one** of the following that puts the youth at risk of out of home placement: 1. Persistent and deliberate attempts to intentionally inflict serious injury on another person; 2. Ongoing dangerous or destructive behavior that is evidenced by repeated occurrences of behaviors that are endangering to self or others are difficult to control, cause distress, or negatively affect the youth's health; 3. Increasing and persistent symptoms associated with depression (e.g. chronic irritability, anhedonia, significant changes in sleep/eating, disrupted emotion regulation, …) or anxiety (e.g. rumination, panic attacks, hypervigilance, dissociation, …), in combination with externalizing problems (e.g. physical and verbal aggression, truancy, stealing, property destruction, lying, etc.) that have contributed to decreased functioning in the community; 4. Ongoing substance use or dependency that interfere with the youth's interpersonal relationships and functioning in the community. 5. The youth is returning home from out-of-home placement and FFT is needed as step down service from an out-of-home placement. 4. The youth's successful reintegration or maintenance in the community is dependent upon an integrated and coordinated treatment approach that involves intensive family/caregiver partnership through the FFT model. Participation in an alternative community-based service would not provide the same opportunities for effective intervention for the youth's problem behaviors. 5. There is a family member or other committed caregiver available to participate in this intensive service. 6. Arrangements for supervision at home/community are adequate to ensure a reasonable degree of safety and a safety plan has been established or will be quickly established by the FFT program as clinically indicated.
Exclusion Criteria	Youth who meet any one of the criteria below are not eligible to receive FFT: • The youth is currently experiencing active suicidal, homicidal or psychotic behavior that requires continuous supervision that is NOT available through the provision of FFT. • The youth is living independently, or a the provider cannot identify a primary caregiver for participation despite extensive efforts to locate all extended family, adult friends and other potential surrogate caregivers. • The youth's presenting problem is limited to sexually harmful or dangerous behavior in the absence of other externalizing behaviors. • The youth's functional impairment is solely a result of Developmental Disability, as defined in the Code of Virginia § 37.2-100.
Continued Stay Criteria - Diagnosis, Symptoms, and Functional Impairment	Within the past thirty (30) calendar days, FFT continues to be the appropriate level of care for the youth as evidenced by at least one of the following: • The youth's symptoms/behaviors and functional impairment persist at a level of severity adequate to meet admission criteria; • The youth has manifested new symptoms that meet admission criteria and those have been documented in the ISP; • Progress toward identified ISP goal(s) is evident and has been documented based upon the objectives defined for each goal, but not all of the treatment goal(s) have been achieved. To consider approval for continued stay requests, documentation will be reviewed and should demonstrate active treatment and care coordination through all of the following: • An ISP with evaluation and treatment objectives appropriate for this level of care and type of intervention. The treatment must support community integrative objectives including the development of the youth's network of personal, family, and community support. Treatment objectives are related to readiness for discharge and FFT specific expected outcomes; • Progress toward objectives is being monitored weekly within fidelity to the model; • The youth and family/caregiver are actively involved in treatment, or the provider has documented active, persistent efforts that are appropriate to improve engagement; • The type, frequency and intensity of interventions are consistent with the ISP and fidelity to the model; • The provider is making vigorous efforts to affect a timely transition to an appropriate lower level of care. These efforts require documentation of discharge planning beginning at the time of admission to include communication with service practitioners, community partners, and natural supports that will meet the needs of the client; • The provider has developed an individualized discharge plan that includes specific plans for appropriate follow-up care. If youth does not meet the above continued stay criteria, FFT may still be authorized for up to an additional 10 calendar days under any of the following circumstances: • - ▪ • There is no less intensive level of care in which the objectives can be safely accomplished; or • The youth can achieve certain treatment objectives in the current level of care and achievement of those objectives will enable the youth to be discharged directly to a less intensive community service rather than to a more restrictive setting; or • The youth is scheduled for discharge, but the youth requires services at discharge which are still being coordinated and are not currently available.
Discharge Criteria	The youth meets discharge criteria if any of the following are met: • - ▪ • The youth's documented ISP goals and objectives have been substantially met and all FFT phases have been completed; • The youth no longer meets admission criteria due to the following: • - ▪ • The youth's needs can be met at a lower level of care; ▪ The youth's current level of function requires a higher level of care; ▪ The youth or the youth's family have not benefited from FFT despite documented efforts to engage the youth or family and there is no reasonable expectation of progress at this level of care despite ISP changes or the youth or the youth's family has achieved maximal benefit from this level of care; ▪ The youth is placed in a hospital, skilled nursing facility, residential treatment facility, or other residential treatment setting and is not ready for discharge within 14 consecutive calendar days to a family home environment or a community setting with community-based support; ▪ Required consent for treatment is withdrawn; or ▪ If there is a lapse in service greater than 31 consecutive calendar days, the provider shall discharge the youth.
FFT Service Authorization and Utilization Review	
Service Authorization	This service requires prior authorization and can only be provided by a treatment provider who is licensed by FFT, LLC., and licensed by the Department of Behavioral Health and Developmental Services for Mental Health Outpatient Services. Providers shall submit service authorization requests within one business day of admission for initial service authorization requests and by the requested start date for continued stay requests. If submitted after the required time-frame, the begin date of authorization will be based on the date of receipt. • Service units are authorized based on medical necessity with a unit equaling fifteen minutes • The following should be included with Continued Stay requests: - The continued stay service authorization form - Updated ISP/FFT Behavior Change Plan that reflects the current goals and interventions - Original Comprehensive Needs Assessment, and an addendum to this assessment (can be in a progress note) that briefly describes any new information impacting care, progress and interventions to date, and a description of the rationale for continued service delivery. The information provided for service authorization must be corroborated and in the provider's clinical record. An approved Service Authorization is required for any units of FFT to be reimbursed. Additional information on service authorization is located in Appendix C of the manual. Service authorization forms and information on Medicaid MCOs processes are located at www.dmas.virginia.gov/for-providers/behavioral-health/training-and-resources/.
Documentation and Utilization Review	Refer to Chapter VI of this manual for documentation and utilization review requirements.

FFT Billing Guidance

One unit of service equals fifteen minutes. To bill a service unit, a qualified FFT team member must provide a covered service for a minimum of 15 minutes.

Booster sessions provided by a LMHP, LMHP-R, LMHP-RP or LMHP-S may be billed using appropriate outpatient psychiatric services CPT codes.

Providers must bill with the appropriate team modifiers:

Modifier	**Modifier Meaning**
HN	Established Team with one (QMHP-C/E or CSAC/S)-Bachelor's Level Degree
HO	Established Team with one (QMHP-C/E or CSAC/S)-Masters' Level Degree **or** All LMHP types
HK, HN	New Team with one (QMHP-C/E or CSAC/S) Bachelor's Level Degree
HK, HO	New Team with one (QMHP-C/E or CSAC/S)-Masters' Level Degree **or** All LMHP types

Coverage of services delivered by telehealth are described in the "Telehealth Services Supplement". MCO contracted providers should consult with the contracted MCOs for their specific policies and requirements for telehealth.

Billing Code	Unit	Description	Notes	Provider Qualifications
H0036 and modifiers as appropriate	Per 15 minutes	Functional Family Therapy		Service components must be provided by a qualified provider (see Provider qualification and staff requirements section)
H0036 and modifiers as appropriate	Per 15 minutes	Comprehensive Needs Assessment		LMHP, LMHP-R, LMHP-RP, LMHP-S

90791	n/a	Psychiatric Diagnostic Evaluation	This code should be used when a LMHP, LMHP-R, LMHP-RP or LMHP-S conducts the comprehensive needs assessment, determines that the youth does not meet MNC and will not enter the service.	LMHP, LMHP-R, LMHP-RP, LMHP-S,

Applied Behavior Analysis (ABA) (effective 12/1/2021)

ABA Level of Care Guidelines	
Service Definition	"Applied Behavior Analysis" or "ABA" means the practice of behavior analysis as established by the Virginia Board of Medicine in § 54.1-2900 as the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.
Critical Features & Service Components	ABA services must include the following four characteristics: 1. An objective assessment and analysis of the client's condition by observing how the environment affects the client's behavior, as evidenced through appropriate data collection. 2. Importance given to understanding the context of the behavior and the behavior's value to the youth, the family, and the community. 3. Utilization of the principles and procedures of behavior analysis such that the client's health, independence, and quality of life are improved. 4. Consistent, ongoing, objective assessment and data analysis to inform clinical decision-making. Family training related to the implementation of ABA shall be included. ABA may be provided in the home or community settings where the targeted behaviors are likely to occur. ABA may also be provided in clinic settings. Limited services are allowed in the school setting (see service limitations section). The setting must be justified in the ISP. Refer to the Billing Guidance section for a list of approved Current Procedural Terminology (CPT) codes.

Required Activities	The following required activities apply to ABA: • An initial assessment for ABA consistent with the components required in the Comprehensive Needs Assessment (see Chapter IV for requirements), documenting the youth's diagnosis/es and describing how service needs match the level of care criteria must be completed at the start of services. The initial assessment must: • be completed by the LBA, LABA or LMHP acting within the scope of practice. Other qualified staff may assist with the completion of an assessment (see staff requirements section); • be conducted in-person with the youth and the youth's family/caregivers; • The youth has met criteria for a primary diagnosis consistent with the most recent version of Diagnostic and Statistical Manual (DSM) relevant to the need for ABA; • Include a functional assessment using validated tools completed by the LBA, LABA or LMHP acting within the scope of practice. • include the reasons the youth needs ABA including how the youth meets medical necessity and eligibility criteria for the service; • include information about the targeted behaviors including frequency, duration, and intensity; • The LBA, LABA or LMHP must, at a minimum, observe the youth monthly. Assessments must be reviewed and updated at least annually by the LBA, LABA or LMHP. • Individual Service Plans (ISPs see Chapter IV for requirements) shall be required during the entire duration of services and must be current. ISPs must be reviewed at a minimum of every 30 calendar days or more frequently depending on the youth's needs. Refer to Chapter IV for additional guidance and documentation requirements for the 30 day review as well as additional quarterly review requirements. In addition to the requirements in Chapter IV, ISPs must include: • Youth Focused ABA Treatment Goals and Objectives • All preliminary goals and objectives presented in a way that summarizes and defines the overall approach to the youth's treatment based on the clinical needs and target behaviors as defined in the assessment summary; • Prioritization of the treatment focus defined according to the severity of need; • Description of how the provider will measure progress; • Baseline status (as identified during the assessment and parent interviews) describing the intensity, frequency and duration of each behavior that is targeted for therapy; and • Parent and Caregiver Goals and Objectives • Describe the goals for parent/caregiver education related to the youth's behaviors to be achieved within the authorized time period; • Describe the specific objectives and the methods used to measure progress within each goal area; and • Describe the goals for other care provider's education related to the youth's behaviors. Other care providers may include Medicaid Home and Community Based Waiver funded attendants and relatives who routinely come in contact with the youth. • Care Coordination Goals • Specific description of the care coordination and/or referral activities that will be implemented by the provider within the authorized time period to facilitate ISP outcomes based on the assessed needs of the youth and family including the families desired outcomes from receiving services; • Specific care coordination treatment goals and the desired outcome based on the services provided by the ancillary service provider; • Referrals to medical services (such as Speech-Language Pathology services, Occupational Therapy, Physical Therapy, Neurological services and Psychiatric services) and case management services to facilitate access to desired medical services including the desired outcome from the collaborative efforts with each therapeutic discipline including the target dates for achievement; and • All goals and objectives presented in a way that summarizes and defines the overall approach including the prioritization of the treatment goals based on the clinical needs and target behaviors as defined in the assessment summary. • Providers must communicate the results of the assessment and treatment planning to the youth's primary care provider. Care coordination with the youth's primary care provider is an essential component of the provision of ABA services and must be documented in the youth's record • Providers must follow all requirements for care coordination (See Care Coordination Requirements of Mental Health Providers section of Chapter IV). • Family training related to the implementation of ABA must be included. Family training involving the youth's family and significant others shall: • be for the direct benefit of the youth and not for the treatment needs of the youth's family or significant others; • occur with the youth present except when it is clinically appropriate for the youth to be absent in order to advance the youth's treatment goals; and, • be aligned with the goals of the youth's ISP. • Direct family involvement in the treatment program is required at a minimum of weekly but the amount of direct interaction with the treatment provider will vary according to the clinical necessity, progress as documented, and the youth and family goals in the ISP. Family involvement includes, but is not limited to, assessment, family training, family observation during treatment, updating family members on the youth's progress and involving the family in updating treatment goals. • Clinical supervision shall be required for services rendered by a LABA, LMHP-R, LMHP-RP, or LMHP-S. Clinical supervision must be consistent with the scope of practice as described by the applicable Virginia Department of Health Professions (DHP) regulatory board. • Supervision of unlicensed staff shall occur at least twice a month by the licensed supervisor. As documented in the youth's medical record, supervision shall include a review of progress notes and data and dialogue with supervised staff about the youth's progress and effectiveness of the ISP. Supervision shall be demonstrated by, at a minimum, the contemporaneously dated signature of the supervision activities by the licensed supervisor.

Service Limitations	In addition to the "Non-Reimbursable Activities for all Mental Health Services" section in Chapter IV, the following service limitations apply: • Group treatment should include no more than five youth. Multiple family group treatment should include no more than five caregivers. Groups may exceed this size based on the clinical determination of the LBA, LABA or LMHP. The LBA, LABA or LMHP must document the clinical justification for larger group sizes. • ABA CPT codes are limited to 97151, 97152, 97156 and 97157 in Residential Treatment Services settings including Therapeutic Group Homes (TGHs) and Psychiatric Residential Treatment Facilities (PRTFs). • Services cannot be authorized concurrently with - Intensive In-Home, - Mental Health Skill Building, - Psychosocial Rehabilitation, - Partial Hospitalization Program, - Assertive Community Treatment. - 14-calendar day service authorization overlap with these services is allowed as youth are being admitted or discharged from ABA to other behavioral health services (see service authorization section). • The following shall not be covered under ABA: • Services that are based upon an incomplete, missing, or outdated assessment or ISP. • Sessions that are conducted for recreation respite or child care. • Services rendered primarily by a relative or guardian who is legally responsible for the youth's care. • Services that are provided in the absence of the youth or a parent or other authorized caregiver identified in the ISP. • Services provided by a local education agency. ABA may only be provided in the school setting when the purpose is for observation and collaboration related to behavior and skill acquisition (not direct therapy) and services have been authorized by the school, parent and provider and included in the ISP.
ABA Provider Participation Requirements	
Provider Qualifications	ABA providers must be licensed by the applicable health regulatory board at the Virginia Department of Health Professions (DHP), credentialed with the youth's Medicaid MCO for youth enrolled in Medicaid managed care or the Fee for Service (FFS) contractor for youth in FFS (see Chapter II for additional information on credentialing). ABA providers must follow all general Medicaid provider requirements specified in Chapter II of this manual.
Staff Requirements	ABA may be provided by: • An LBA or LMHP acting within the scope of practice defined by the applicable health regulatory board; • An LMHP-R, LMHP-RP or LMHP-S under supervision as defined by the applicable Virginia Health Regulatory Board; • An LABA under the supervision of a LBA as specified in 18VAC85-150-120; • Personnel under the supervision of a LBA or LABA in accordance with 18VAC85-150-10 et seq. of the Virginia Board of Medicine regulations; and • Personnel under the supervision of a Licensed Clinical Psychologist in accordance with §54.1-3614. Tasks performed by unlicensed personnel cannot constitute the practice of behavior analysis in accordance with 18VAC85-150-130. Unlicensed personnel includes, but is not limited to Registered Behavior Technicians (RBTs).
ABA Medical Necessity Criteria	
Admission Criteria Diagnosis, Symptoms, and Functional Impairment	All of the following criteria must be met: • The youth must have a current psychiatric diagnosis as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM) or have a provisional psychiatric diagnosis as developed by an LMHP when no definitive diagnosis has been made; • The youth must meet at least two of the following criteria on a continuing or intermittent basis: • Non-verbal or limited functional communication and pragmatic language, unintelligible or echolalic speech, impairment in receptive and/or expressive language; • Severe impairment in social interaction /social reasoning /social reciprocity/ and interpersonal relatedness; • Frequent intense behavioral outbursts that are self-injurious or aggressive towards others; • Disruptive obsessive, repetitive, or ritualized behaviors; or • Difficulty with sensory integration; • There is a family/caregiver available to participate in this intensive service.
Exclusion Criteria	Services cannot be authorized concurrently with Intensive In-Home, Mental Health Skill Building, Psychosocial Rehabilitation, Partial Hospitalization Program or Assertive Community Treatment. 14-calendar day service authorization overlap with these services is allowed as youth are being admitted or discharged from ABA to other behavioral health services (see service authorization section).

Continued Stay Criteria - Diagnosis, Symptoms, and Functional Impairment	Within the past thirty (30) calendar days, the youth has continued to meet the admission criteria for ABA as evidenced by at least one of the following: • The youth's symptoms/behaviors and functional impairment persist at a level of severity adequate to meet admission criteria; • The youth has manifested new symptoms that meet admission criteria and those have been documented in the ISP; • Progress toward identified ISP goal(s) is evident and has been documented based upon the objectives defined for each goal, but not all of the treatment goal(s) have been achieved. To consider approval for continued stay requests, documentation will be reviewed and should demonstrate active treatment and care coordination through all of the following: • An individualized ISP with evaluation and treatment objectives appropriate for this level of care and type of intervention; • Progress toward objectives is being monitored as evidenced in the 30 calendar day ISP review documentation; • The youth and family/caregiver are actively involved in treatment, or the provider has documented active, persistent efforts that are appropriate to improve engagement; • The type, frequency and intensity of interventions are consistent with the ISP; • The provider has developed an individualized discharge plan that includes specific plans for appropriate follow-up care. If youth does not meet criteria for continued treatment, ABA may still be authorized for up to an additional 10 calendar days under any of the following circumstances: • - ▪ • There is no less intensive level of care in which the objectives can be safely accomplished; or • The youth can achieve certain treatment objectives in the current level of care and achievement of those objectives will enable the youth to be discharged directly to a less intensive community service rather than to a more restrictive setting; or • The youth is scheduled for discharge, but the youth requires services at discharge which are still being coordinated and are not currently available.
Discharge Criteria	The provider must terminate ABA if the service is no longer medically necessary. The service is no longer deemed medically necessary if one of the following criteria is met within a 30 day time period: 1. No meaningful or measurable improvement has been documented in the youth's behavior(s) despite receiving services according to the ISP; there is reasonable expectation that the family and /or caregiver are adequately trained and able to manage the youth's behavior; and termination of the current level of services would not result in further deterioration or the recurrence of the signs and symptoms that necessitated treatment. 2. Treatment is making the symptoms persistently worse or youth is not medically stable for ABA to be effective; 3. The youth has achieved adequate stabilization of the challenging behavior and less intensive modes of therapy are appropriate; 4. The youth demonstrates an inability to maintain long-term gains from the proposed ISP; or 5. The family and/or caregiver refuses or is unable to participate meaningfully in the behavior treatment plan. If there is a lapse in service for more than 30 consecutive calendar days, the provider must discharge the youth from services and notify the FFS Contractor or MCO. If services resume after a break of more than 30 consecutive calendar days, a new service authorization request including a new assessment and ISP must be submitted to the FFS Contractor or MCO.
ABA Service Authorization and Utilization Review	

Service Authorization	Assessment CPT codes do not require service authorization. All treatment service hours require service authorization. Providers shall submit service authorization requests by the requested start date of services. If submitted after the required time-frame, the begin date of authorization will be based on the date of receipt. The ABA provider must submit the following information to the FFS Contractor or MCO for the initial service authorization: • Initial Service Authorization Request Form • The provider assessment completed by the LBA, LABA or LMHP; • The preliminary ISP; and, • A description of the preliminary discharge plan to include referrals as service goals are met. For all requests exceeding 20 hours (80 units) or more per week, the schedule of activities used to structure the service sessions and describe how the activity will facilitate the implementation of the ABA treatment. Each session must clearly be related to the successful attainment of the treatment goals. The therapeutic function of all scheduled sessions must be clearly defined regarding the number of hours requested. Continuation of service requests must include: • Continued Stay Service Authorization Form • Original Comprehensive Needs Assessment and an addendum to this assessment (can be in a progress note) that briefly describes any new information impacting care, progress and interventions to date, and a description of the rationale for continued service delivery. • An updated ISP that reflects the current goals and interventions • A summary of the youth's treatment progress that contains the following information: • Graphical presentation of progress on each goal and objective in the ISP; • Overview of family involvement during service period with regards to the youth's ISP to include: who has been involved; progress made and continuing needs of family goals/training to include reasons the youth and parent/caregiver need continued ABA. • A summary of progress towards generalization of adaptive functioning in multiple settings to include assessing for maintenance of the skills acquired and updating the ISP as needed to test for generalization of skills in multiple environments; • Progress toward the anticipated date of discharge from services including any plan to gradually reduce services and consultative actions as planned to include identifying lower levels of care, natural supports care coordination needs; • A summary of the care coordination activities. Based on the needs of the youth and family/caregiver, it may be appropriate to request a service authorization extension at a reduced number of hours to assist the youth and family to successfully transition from a higher intensity of ABA services to a lower level of service. The provider must notify the FFS Contractor or MCO of all service discharges or transfers within three business days of the last date of service. Additional information on service authorization is located in Appendix C of the manual. Service authorization forms and information on Medicaid MCOs processes is located at www.dmas.virginia.gov/for-providers/behavioral-health/training-and-resources/.
Documentation and Utilization Review	Refer to Chapter VI of this manual for documentation and utilization review requirements. Additional documentation requirements include: • An assessment of adaptive functioning required to support medical necessity criteria; • Documentation of the family's agreement for participation in therapy as defined in the ISP; • Ongoing treatment documentation data including graphical analysis of goals and objectives as defined by the most current ISP for those dates of service; • Description of any assessment tools used; • Documentation that indicates the coordination of treatment with the youth's primary care provider and other health disciplines and coordination of the relevant documentation necessary for ongoing behavioral treatment; • The initial assessment completed by the LBA, LABA or LMHP including: the assessment instruments used; dates of services and face to face contacts; documentation of other interviews conducted as part of the assessment process; staff and participant names; and staff credentials and signatures; • Documentation of the activities provided, length of services provided, the reaction to that day's activity, and documentation of performance in each treatment objective. At a minimum, the description of treatment progress should be documented through daily data collection as well as a weekly summary note; • Documentation of family education and their application of effective behavior strategies as designed in the ISP; • Documentation shall be prepared to clearly demonstrate efficacy using baseline and service-related data that shows clinical progress. Documentation shall include demonstration of generalization for the youth and progress for family members toward the therapy goals as defined in the service plan. • Documentation of all billed services shall include the amount of time or billable units spent to deliver the service and shall be signed and dated on the date of the service by the practitioner rendering the service and include any applicable supervisor co-signature.

ABA Billing Guidance

1. Payment is available only for allowable activities that are provided by a qualified provider in accordance with an approved ISP. Services other than assessment (97151, 97152 and 0362T) must be service authorized by the FFS contractor or MCO.

2. Units are service authorized under 97155 but providers must bill for services using the appropriate CPT code for the actual service provided. CPT codes must also be billed using the appropriate modifier for the professional providing the service:

Staff	Modifier
LABA	HN
LBA	HO
LMHP	TF

3. CPT codes requiring a qualified healthcare professional (QHP) must be provided by a LBA or LMHP. An LABA may also act as a qualified healthcare professional as determined by the supervising LBA in accordance with 18VAC85-150-120. An LMHP-R, LMHP-RP or LMHP-S who has completed education and training in ABA may provide these services under the supervising LMHP.

4. CPT codes for services provided by a technician must be provided by one of the following:

   a. An LMHP-R, LMHP-RP or LMHP-S under supervision as defined by the applicable Virginia Health Regulatory Board
   b. An LABA under the supervision of a LBA
   c. Personnel under the supervision of a LBA or LABA in accordance with 18VAC85-150-10 et seq. of the Virginia Board of Medicine regulations.
   d. Personnel under the supervision of a Licensed Clinical Psychologist in accordance with §54.1-3614.
   e. An LBA or LMHP acting as the technician.

5. Assessment codes 97151, 97152 and 0362T may be billed as part of the initial assessment and reassessments.

6. Care coordination, data analysis and treatment plan preparation activities provided by the QHP without the youth present may be billed under 97151 at the time of the initial assessment and reassessments.

7. To bill for time spent by the QHP to review data, modify the treatment protocol and provide additional care coordination as part of ongoing assessments, the QHP must bill under 97155.

8. For Group Treatment (97154 and 97158):

    a. Providers may bill 97154 and 97158 for youth in the same group depending on whether the youth has an assigned one to one technician during group treatment.
    b. Providers must use 97158 to bill for youth in the group with an assigned one to one technician during group treatment. Providers may not bill an additional technician level code when billing 97158 or 97154.
    c. With the exception of LMHPs and LBAs acting as a technician, on-site oversight of a LBA is required for billing 97154.
    d. The total group size may not exceed five youth unless the LBA, LABA or LMHP documents justification for larger group sizes.

9. Group Family Treatment (97157) may not exceed five caregivers unless the LBA, LABA or LMHP documents justification for larger group sizes.

10. It is expected that the team-based codes 0373T and 0362T will be utilized only when medically necessary where there is documented harm to self and others by the youth. Team-based treatment codes are expected to be for a short duration with the frequency of treatment tapering to individual treatment over time as the youth's treatment goals are met. The LBA, LABA or LMHP does not need to be present the entire time when billing team-based codes but must be on-site, immediately available and interruptible to provide assistance and direction. Billing for 0362T and 0373T requires four criteria to be met. The assessment or treatment must be:

    a. administered by a QHP who is on site;
    b. with the assistance of two or more technicians;
    c. for a youth who exhibits destructive behavior; and,

d. completed in an environment that is customized to the youth's behavior. Customized means that the environment is configured to safely conduct a functional analysis of destructive behavior (0362T) or treatment for that behavior (0373T).

11. If two technicians are required for treatment and the LBA is not required to be on-site, the provider must document the reason why two technicians are required in the ISP and bill 97153 for each technician. The reasons for the two technicians and anticipated duration of treatment must be documented in the ISP submitted to the MCO as part of the service authorization.

12. The following billing code combinations may be billed at the same time:

    a. 97152 may be billed at the same time as 97151 (with the exception of 97152 HN together with 97151 HN).
    b. 97153 may be billed at the same time as 97155 (with the exception of 97153 HN together with 97155 HN).
    c. 97154 and 97158 may be billed at the same time for different youth in the same group (professional level modifier must be identical).
    d. 97153 may be billed at the same time for two technicians when documented in the ISP that has been service authorized by the MCO.
    e. Services provided with a youth can be billed at the same time as family and group family training if the services are provided by different qualified staff members (i.e. one staff with the youth and one staff with the family/caregiver).

    For additional information refer to the ARTS/MHS Doing Business Spreadsheet https://www.dmas.virginia.gov/for-providers/behavioral-health/training-and-resources/.

13. Coverage of services delivered by telemedicine are described in the "Telehealth Services Supplement". MCO contracted providers should consult with the contracted MCOs for their specific policies and requirements for telehealth.

Billing Code	Unit	Description	Provider Qualifications
97151 and staff modifier	per 15 min	Behavior identification assessment, administered by a physician or other qualified healthcare professional, each 15 minutes of the physician's or other qualified healthcare professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan.	LBA/LMHP[1]/LABA[2]
97152 and staff modifier as appropriate	per 15 min	Behavior identification supporting assessment, administered by one technician under the direction of a physician or other qualified healthcare professional, face-to-face with the patient, each 15 minute.	Qualified staff
97153 and staff modifier as appropriate	per 15 min	Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified healthcare professional, face-to-face with one patient, each 15 minutes.	Qualified staff
97154 and staff modifier as appropriate	per 15 min	Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified healthcare professional, face-to-face with two or more patients, each 15 minutes.	Qualified staff
97155 and staff modifier	per 15 min	Adaptive behavior treatment with protocol modification, administered by physician or other qualified healthcare professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes.	LBA/LMHP[1]/LABA[2] May also include technician and/or caregiver. (technician billed separately)
97156 and staff modifier	per 15 min	Family adaptive behavior treatment guidance, administered by physician or other qualified healthcare professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes.	LBA/LMHP[1]/LABA[2]

97157 and staff modifier	per 15 min	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified healthcare professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes.	LBA/LMHP[1]/LABA[2]
97158 and staff modifier	per 15 min	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified healthcare professional, face-to-face with multiple patients, each 15 minutes. This code is used when the youth also has an assigned one to one technician present during the group treatment.	LBA/LMHP[1]/LABA[2] Youth also has assigned 1:1 technician (technician not billed separately)
0362T and staff modifier	per 15 min	Behavior identification supporting assessment, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: • administered by the physician or other qualified healthcare professional who is on site; • with the assistance of two or more technicians; • for a patient who exhibits destructive behavior; • completed in an environment that is customized to the patient's behavior.	Two or more technicians **and** LBA/LMHP[1]/LABA[2] (team rate)
0373T and staff modifier	per 15 min	Adaptive behavior treatment with protocol modification, each 15 minutes of technicians' time face-to face with a patient, requiring the following components: • administered by the physician or other qualified healthcare professional who is on site; • with the assistance of two or more technicians; • for a patient who exhibits destructive behavior; • completed in an environment that is customized, to the patient's behavior	Two or more technicians and LBA/LMHP[1]/LABA[2] (team rate)

[1] An LMHP-R, LMHP-RP or LMHP-S who has completed education and training in ABA may provide under the supervising LMHP.

[2] An LABA may act as a qualified healthcare professional as determined by the supervising LBA in accordance with 18VAC85-150-120.